



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

SOUTHWEST CENTER MEDICAL PA
7125 MARVIN D LOVE FWY #107
DALLAS TX 75237

DWC Claim #: 12116592

Injured Employee: JERRY HURNDON

Date of Injury: SEPTEMBER 16, 2011

Employer Name: PERHAM TRUCKING INC

Insurance Carrier #: 9787903

Respondent Name

PROTECTIVE INSURANCE CO

Carrier's Austin Representative Box

Box Number 17

MFDR Tracking Number

M4-13-0470-01

MFDR Date Received

OCTOBER 15, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We submitted our bills to the carrier. The carrier failed to reimburse preauthorized services. Our preauthorization request asked for CPT codes 97110 (8 units) and 97530 (8 units). The carrier changed our preauthorization request without our permission. There was no Peer to Peer done. The request was changed without our permission. We submitted a Request for Reconsideration submitting proof that we requested codes 97110 and 97530. After the Request for Reconsideration, the carrier did pay 2 dates of service, but failed to reimburse the remaining dates of preauthorized services."

Amount in Dispute: \$1,508.87

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: A response to the request for medical fee dispute resolution was not submitted by the insurance carrier or its agent.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 26, 2011 through November 23, 2011	CPT Code 97530-GP	\$1,508.87	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.600 sets out the guidelines for obtaining preauthorization.
3. 28 Texas Administrative Code §134.302 sets out reimbursement for reimbursement of professional services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 197 – Payment adjusted for absence of precert/preauth

- 168 – No additional allowance recommended.
- 198 – Payment adjusted for exceeded precert/preauth.
- 193 – Original payment decision maintained.

Issues

1. Where the services in dispute preauthorized?
2. Is the requestor entitled to reimbursement?

Findings

1. In accordance with 28 Texas Administrative Code §134.600(p)(5)(A)(ii) non-emergency health care requiring preauthorization includes therapeutic procedures, excluding work hardening and work conditioning. Review of the preauthorization approval finds that CPT Codes 97110 and 97140 were approved by CorVel on behalf of the insurance carrier. The requestor has billed CPT Code 97750-GP, which is not one of the codes that was preauthorized.
2. The Division finds that reimbursement is not recommended for the non-authorized code.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

_____	_____	_____
Signature	Marguerite Foster Medical Fee Dispute Resolution Officer	October 10, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, 37 *Texas Register* 3833, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).